General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 158 Central Road, WORCESTER PARK, Surrey, KT4 8HH

Pharmacy reference: 1036850

Type of pharmacy: Community

Date of inspection: 13/02/2020

Pharmacy context

This is a small branch of Boots on the main road in Worcester Park, Surrey. It is accredited as a Healthy Living Pharmacy (HLP). It dispenses NHS and private prescriptions, sells a range of over-the-counter medicines and provides health advice. The pharmacy offers flu vaccinations in the autumn and winter seasons

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	1.2	Good practice	Records of errors, near misses and other patient safety incidents are regularly and comprehensively reviewed by the patient safety champion, and records are kept showing what has been learned and what has been done to improve the safety and quality of services provided.
2. Staff	Standards met	2.2	Good practice	Records show that staff undertake regular training to keep their knowledge and skills up to date. They can and do access training materials online both at work and at home.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy provides its services in line with clear, up-to-date processes and procedures which are being followed by its team members. They are clear about their roles and responsibilities. And they work to professional standards, identifying and managing risks effectively. The pharmacy keeps satisfactory records of the mistakes it makes during the dispensing process. The patient safety champion regularly reviews them with members of the team so that they can learn from them and avoid problems being repeated. The pharmacy generally manages and protects confidential information adequately and tells people how their private information will be used. Team members understand their role in helping to protect the welfare of vulnerable people. The pharmacy has adequate insurance in place to help protect people if things do go wrong.

Inspector's evidence

There were Standard Operating Procedures (SOPs) in place to underpin all professional standards, seen as signed and read by staff. Several, including the responsible pharmacist (RP) SOPs, had been updated in November 2018 and due a review in November 2020. The SOPs for controlled drugs (CDs) were dated November 2019 and due to be reviewed in November 2021. There were also signed training logs present in the folder for the new SOPs verifying that each member of staff had read and understood them. Staff roles and responsibilities were all set out in a matrix within the SOP folder, and staff were all clear on the correct procedures to follow.

Errors and near misses were seen to be regularly recorded on a report form kept by the dispensing workstation. The pharmacy advisor, who had been recently appointed as the 'patient safety champion,' reviewed them and completed the 'Patient Safety Review' (PSR) every month for head office. Errors and near misses were discussed individually with each member of staff on a regular monthly basis. Reported near misses had significantly reduced since the introduction of the new Columbus patient medication record (PMR) system. According to both the RP and the pharmacy advisor, scanning product barcodes had almost eliminated selection errors. They both emphasised the need to scan every individual pack rather than scanning one pack multiple times. They highlighted 'Look Alike Sound Alike' (LASA) drugs on the PIF to help avoid picking errors. They had also put 'select and speak' signs on cartons adjacent to the LASAs as a prompt when picking those items. Some items such as sulphonylureas and methotrexate had been put on a separate shelf to minimise the risk of error.

A business continuity plan with emergency contact details was available in the dispensary. There was also an emergency cascade (flowchart and contact list) on the dispensary wall for easy access. People working in the pharmacy were able to clearly explain what they do, what they were responsible for and when they might seek help. The responsible pharmacist (RP) log was seen to be complete and up to date. Staff were able to describe what action they would take in the absence of the responsible pharmacist, and they explained what they could and could not do. The responsible pharmacist notice was correct and clearly displayed for patients to see.

Results of the latest Community Pharmacy Patient Questionnaire (CPPQ) were not on display in the pharmacy but were available online. Results were positive and highlighted a wish for improvements to the prescription waiting area. There was a complaints procedure in place, and this was detailed in a patient guide leaflet in the leaflet stand by the dispensary reception. It included contact details for the

company's head office, Patient Advice and Liaison Service (PALS) and the Independent Complaint Advocacy Service. Credit card style prompt cards for seeking feedback were also available at the prescription reception counter. A certificate of professional indemnity and public liability insurance from XL Insurance Co. Ltd was held electronically on the company's intranet.

Private prescription records were maintained electronically on the Patient Medication Record (PMR) system. A sample of records were checked, and some were seen to have the incorrect prescriber details recorded. This was discussed and the manager made notes to brief the rest of the team. The RP explained that they didn't make very many emergency supplies since they had tightened up their procedures. People had been asking for an emergency supply rather than ordering their prescription(s) in sufficient time. The emergency supply records were maintained electronically, complete with details of the emergency and the reason for supply. Some of those records did not contain enough detail within the reason for supply. The RP noted this and agreed to ensure that more detail would be recorded in future.

The controlled drug (CD) register was seen to be correctly maintained, including the full supplier addresses where required. Running balances were checked weekly in accordance with the SOP. Stock balances of two random samples were checked and found to be correct. Records of CDs returned by patients were seen to be made upon receipt and subsequent destruction documented and witnessed. There were a significant number of returns awaiting destruction as the RP was waiting for a visit from her area manager in order to destroy them. Records of unlicensed 'specials' were seen and found to be complete. Access to the CD keys was recorded daily in the CD key log, stored within the pharmacy duty folder.

All staff were able to demonstrate an understanding of data protection and had undergone General Data Protection Regulation (GDPR) training. They were able to provide examples of how they protect patient confidentiality, for example taking patients aside or speaking quietly when discussing sensitive information. Confidential waste was kept separate from general waste and taken away three times a week to be shredded offsite. The annual Data Security and Protection (DSP) toolkit had been completed, and there was a privacy notice for people to read when signing up to one of the pharmacy's services. Completed prescriptions awaiting collection were stored behind the reception counter. Some people's names and addresses could be read by other people waiting at the counter. The pharmacy advisor subsequently turned them around so that they were no longer visible to those waiting at the counter.

There were safeguarding procedures in place and contact details of local referring agencies were in the safeguarding section of the pharmacy duty folder. All registrants had been trained to level 2 and all other staff members had undergone level 1 Boots e-learning. Staff were able to describe some of the signs to look for and knew when to refer to the pharmacist. All staff were dementia friends.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members are well-trained and have a good understanding of their roles and responsibilities. They can make suggestions to improve safety and workflows where appropriate

Inspector's evidence

There were two pharmacy advisors and the responsible pharmacist (RP), on duty during the inspection. The size of the team appeared to be appropriate for the workload. In the event of staff shortages, they could contact the area manager for support such as using relief dispensers or borrowing staff from another branch.

Certificates to confirm staff qualifications were available both online and in paper files to show the levels of training completed. Ongoing training consisted of e-learning modules for staff to complete online. The RP demonstrated the various online communications and training platforms, such as 'pharmacy school' that were available for all staff to access either in the pharmacy or at home. Staff were able to demonstrate an awareness of potential medicines abuse and could identify patients making repeat purchases. All members of staff were seen to serve customers and asking appropriate questions when responding to requests or selling medicines.

The RP confirmed that she was comfortable with making decisions and did not feel pressurised to compromise her professional judgement. There were targets in place but they were applied sensibly. Team members were involved in open discussions about their mistakes and learning from them. Team members said that they could raise concerns and that there was a whistleblowing policy available for them if needed. The RP conducted periodic reviews with her team to discuss performance and areas for development. Each member of staff had an up-to-date personal development plan in place and knew what they were working towards.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises provide a secure and professional environment for people to receive its services. The premises include a private room which the team uses for some of its services and for private conversations. But some people may find it difficult to get to the consultation room. And the premises are showing their age in places.

Inspector's evidence

There was step-free access into the pharmacy through a single manual door. The pharmacy premises were clean and tidy, but were starting to look a bit dated. The dispensary was small but well organised, allowing for separate assembly and checking areas, which were reasonably tidy and free of clutter. There was sufficient space for one person at a time to work safely and effectively in the dispensary. The RP explained how she and the pharmacy advisor took turns working in the dispensary and at the prescription reception workstation to facilitate the assembly and subsequent checking processes.

There was a small health promotion area with posters highlighting current local health priorities. There was a consultation room for confidential conversations, consultations and the provision of services. This could only be accessed via the door leading to the stockroom, and then down a narrow sloping corridor. There was no handrail or other safety feature to help people with reduced mobility safely make their way down the slope to the consultation room. There was a tray in the consultation room containing swabs, gloves and a two adrenaline autoinjectors for use in an emergency.

The sink in the dispensary was clean, had hot and cold running water and handwash available. Room temperatures were appropriately maintained by combined heating and air-conditioning units, keeping staff comfortable and suitable for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy delivers its services in a safe and effective manner, and people with a range of needs can access them. The pharmacy sources, stores and manages its medicines safely, and so makes sure that all the medicines it supplies are fit for purpose. It responds well to drug alerts or product recalls to make sure that people only get medicines or devices which are safe for them to take. It identifies people supplied with high-risk medicines and records the checks that it makes so that they can be given extra information they may need to take their medicines safely.

Inspector's evidence

There was a sign in the shop window listing the pharmacy's opening hours. There was a range of leaflets providing general health information and the services available from the pharmacy. The pharmacy provided a limited range of services including seasonal flu vaccinations which were available during the autumn and winter.

Controls were seen to be in place to reduce the risk of picking errors, such as highlighting LASAs on shelf with 'select & speak' labels. The RP explained how their new Columbus dispensing system also helped to prevent picking errors when the medicines were scanned as they were selected, and near misses had reduced accordingly. The team used PIFs to communicate messages about the patient's medicines to the pharmacist. These were used to highlight new medicines, changes to their medicines, any allergies or whether the patient was eligible for further services, such as an MUR. The form also had a blank box to write any further information that the dispenser thought the pharmacist should be aware of, such as LASAs, or the age and weight if the prescription was for a child. The RP would then initial the note once she had checked it. They used baskets to keep individual prescriptions separate, and prescription labels were initialled to show who had dispensed and checked them. The system also endorsed the prescription tokens with prompts for the staff to sign showing who had labelled, clinically checked, assembled and completed the final check. They also initialled the bag label on the finished prescriptions to complete the audit trail, signifying who had filled the bag and checked that it was complete and correctly labelled. There was a separate signature to show who then handed the bag out to the patient. All of this helped to identify who had been involved at each stage in the process if any query arose after the prescription had been handed out. All the pharmacy's prescriptions were dispensed onsite as they were not using the company's centralised dispensing support pharmacy.

Owings tickets were in use when medicines could not be supplied in their entirety. The prescription was completed as soon as the missing item was back in stock. The manager explained how they checked stock availability every day through the Columbus system, and would obtain some of those items from other local branches if they had spare stock. If the item was likely to be unavailable for some time, the patient would be signposted to their GP for an alternative. The RP confirmed that they were aware of the Serious Shortage Protocol (SSP) but had not yet received any prescriptions for the affected items. She also explained how they carried out an 'exception count' of a number of lines every day to ensure that their stockholding was both accurate and appropriate for their needs.

Prescriptions for CDs or fridge lines in retrieval awaiting collection were highlighted with laminated prompt cards and some put in a separate envelope so that staff would know that there were items to

be collected from the fridge or CD cupboard. The pharmacist demonstrated the process to ensure that schedule 2 controlled drug prescriptions weren't handed out after their 28-day expiry. There were prompt stickers on the bags which included the date after which the prescription could not be handed out, and the token itself was placed in a clear acetate with a red CD card. The dates on Schedules 3 and 4 CD prescriptions were not highlighted in any way to let staff know their expiry date. Upon reflection the RP acknowledged this and agreed to start highlighting schedule 3 and 4 CDs in future to minimise the risk of them being handed out after they had expired. The prescription retrieval shelves were cleared every week of anything over five weeks old. One of the dispensary team would send a reminder text to the patient if possible before the medication was returned to stock and the EPS prescription returned to the NHS spine.

Staff were aware of the risks involved in dispensing valproates to women in the at-risk group, and all such patients were counselled and provided with leaflets and cards highlighting the importance of having effective contraception. The pharmacy had recently completed an audit of valproate patients and all interventions were recorded on the PMR system.

Patients on warfarin were asked if they knew their current dosage, and their INR records were recorded on the PMR system. Some patients didn't always collect their own prescriptions, and their representative wouldn't know their INR result. Patients taking methotrexate and lithium were also asked about blood tests. All of these interventions were recorded on the PMR. There were laminated prompt cards to go with the PIF to ensure that staff checked, and the key points were listed on the reverse to remind them.

Medicines were obtained from licensed wholesalers including Phoenix, AAH, Alliance. Unlicensed 'specials' were generally obtained from Alliance Specials. The pharmacy was using the 'Columbus' PMR system but was not yet using it to decommission stock in accordance with the requirements of the EU Falsified Medicines Directive (FMD).

Routine date checks were seen to be in place, and record sheets were seen for each quarter. Items within three months of their expiry date were recorded on monthly sheets, and any left in stock one month prior to expiry were then disposed of.

Fridge temperatures were recorded daily, and all seen to be within the 2 to 8 degree Celsius range. Staff explained how they would note any variation from this, completing the 'store checklist for investigation of fridge or freezer anomalies' form if necessary. Pharmacy medicines were displayed behind the medicines counter, preventing unauthorised access or self-selection of those medicines.

Patient-returned medicines were screened to ensure that any CDs were appropriately recorded, and that there were no sharps present. Patients returning sharps were signposted to the local council for disposal. There was a tray containing protective gloves and goggles to help staff safely sort through any returned medicines. The pharmacy had no separate purple-lidded hazardous waste container for the disposal of medicines classified as hazardous waste. And there was no list of those medicines available for staff to refer to. The manager agreed to obtain them.

The pharmacy had valid patient group directions (PGDs) in place for both the NHS and private seasonal flu vaccination services. They named the pharmacists accredited to provide the service and were valid until the end of March 2020. The pharmacy kept signed patient consent forms in a file, together with the vaccination records themselves.

The pharmacy received drug alerts and recalls from the MHRA via 'my calendar' on 'Boots Live', printed

copies of which were kept in a file. Each alert was annotated with any actions taken, the date and initials of those involved. The team knew what to do if they received damaged or faulty stock and they explained how they would return them to the wholesalers.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment for the range of services it provides, and it makes sure that it is properly maintained. The pharmacy takes reasonable steps to ensure that people's private information is kept safe and secure.

Inspector's evidence

The pharmacy equipment and facilities were seen to be appropriate for the services provided. The consultation room was clean and tidy. There was a range of crown stamped measuring equipment, counting triangles (including a separate one for cytotoxics, and separate measures marked in red and green for methadone). Reference sources were available, including the BNF and BNF for children. The pharmacy also had internet access and used this as an additional reference source.

Access to PMRs was controlled through individual passwords, which had been changed from the original default password. Computer screens were positioned so they were not visible to the public. Staff were seen to take precautions such as moving to the rear of the dispensary when making telephone calls so as not to be overheard. NHS smartcards were seen in use with no sharing of passwords, and they were not left on the premises overnight.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.